COBURG ENDOSCOPY CENTRE

Patient Label

Doctor: .....

Procedure: .....

Date: ..... **Time:** .....

Surname: ..... **Contacted Patient:** .....

Given Name: ..... **M/F**

Address: .....

Suburb: ..... **Postcode:** .....

Telephone Home: ..... **Work:** .....

Mobile phone number: .....

Date of Birth: Dd/Mm/Yy: ..... **Country of Birth:** .....

Are you Torres Strait Islander/Aboriginal? Yes ☐ No ☐ **Australians only: State Born** .....

Marital Status: ☐ Married ☐ Single ☐ Defacto ☐ Widowed ☐ Divorced

Next of kin: ..... **Relationship:** .....

Transport Home/Carer: ..... **Phone Number:** .....

Family Doctor's Name & Address: .....

Medicare Number: ..... **Reg No:** ..... **Exp:** .....

Pension Number: ..... **DVA Number:** .....

Health Care Card Number: .....

Person Responsible for Account: Patient ☐ Other ☐ Please Specify: .....

Private Health Fund: .....

Table: .....

Membership No: ..... **Confirmed:** Yes ☐ No ☐

Excess Applicable: Yes ☐ No ☐ **Health Fund Contact Name:** .....

Workcover / TAC: **Claim Number:** .....

Employer: .....

Insurance Co.: .....

Financial Consent:

I agree that I am personally responsible for payment of all hospital treatment (including any disposable equipment used) irrespective of any claim I may have against any health funds or other third party. I understand that an administrative fee of $50.00 will be charged for outstanding accounts over 30 days.

Patient Signature: ..... **Date:** .....

THIS FORM IS TO BE RETURNED BEFORE THE ADMISSION DATE

Coburg Endoscopy Centre
15 Munro St., Coburg
Phone 9386 4422
Fax 9386 4433

ADMISSION FORM

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